Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:	M4-09-A298-01
INTEGRA SPECIALTY GROUP 517 N. CARRIER PARKWAY, STE. G GRAND PRAIRIE, TX 75050		
Respondent Name and Box #:		
NORTHERN INSURANCE CO OF NEW YORK REP. BOX #: 19		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as listed on the Table of Disputed Services: "No EOB / NPI # 1922111921 provided on box 33a ."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $604.14
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…This case involves DOS 07/23/08, 07/29/08 08/01/08 and 08/12/08 and has $604.14 in dispute according to the Requestor. The billed items were denied on several grounds as indicated by the EOBs. See Exhibit A. In a nutshell, the bills were submitted late and the treatment was not considered reasonable and necessary per the peer review doctor…"

Principle Documentation:

1. Response to DWC 60
2. Peer Review
3.

PART IV: SUMMARY OF FINDINGS

Dates of Service (DOS)	Denial Code(s)	CPT Codes	Amount in Dispute	Amount Due
07/23/08	283, 200, 29, 854, W9	CPT Code 90801	$207.66	$0.00
07/23/08	283, 200, 29, 854, W9	CPT Code 99080-73	$ 15.00	$0.00
07/23/08	283, 200, 29, 854, W9	CPT Code 99214	$127.32	$0.00
07/29/08, 08/01/08, 08/12/08	283, 200, 29, 854, W9	CPT Code 99213	$ 84.27 $ 84.27 $ 84.27	$0.00 $0.00 $0.00
Total:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.203, titled *Medical Fee Guideline* effective for professional medical services on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "200 – Per 134.801, a medical bill shall not be submitted later than the 1st day of the 11th month (<08/31/05) or 95 days (>09/01/05) after DOS"; "283 – Based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/un-necessary"; "29 – The time limit for filing has expired"; "854 – Unnecessary medical treatment"; "W1 – Workers Compensation state fee schedule adjustment"; and "W9 – Unnecessary medical treatment based on peer review."

2. The Requestor did not submit EOBs for the disputed dates of service. According to the Requestor they never received the first or second denial EOBs. The Requestor submitted a letter and copies of the CMS-1500's from Zurich Managed Care Service Center, dated 09/18/08. Zurich returned the bills to the Requestor and requested the provider to add the NPI number and return the bill. Review of the original billing shows that the NPI number, located in box 33a, was listed on the bills.

3. According to 28 TAC Section 133.307d(2)(B) the Respondents response shall address only those denial reasons presented to the requestor prior to the date of the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MDR will be dismissed in accordance with subsection (e)(2)(G) or (H) of this section. The Respondent submitted EOBs that deny the services in dispute for unnecessary medical.

4. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 TAC Section 133.307(d)(2)(B). As a result, the amount order is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 134.203, 133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor III Medical Fee Dispute Resolution	August 10, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.